Bupa Care Services NZ Limited - Rossendale Dementia Care Home & Hospital

Introduction

This report records the results of a Partial Provisional Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Rossendale Dementia Care Home & Hospital
Services audited:	Hospital services - Psychogeriatric services; Dementia care
Dates of audit:	Start date: 10 December 2021 End date: 10 December 2021

Proposed changes to current services (if any): This audit verified eleven psychogeriatric beds as suitable for beds to dual purpose beds (hospital and rest home) and removal of dementia level care from their current certification.

Total beds occupied across all premises included in the audit on the first day of the audit: 50

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

General overview of the audit

Rossendale Home and Hospital is part of the Bupa group. The service provides psychogeriatric level care for up to 65 residents. On the day of audit there were a total of 50 residents.

This partial provisional audit was completed to assess the suitability and preparedness of the service to provide hospital and rest home level care. The audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with staff and management.

Rossendale is currently being managed by a new, experienced, Bupa manager and a clinical manager. They are supported in their role by the wider Bupa senior regional and national teams.

The previous surveillance audit documented 12 shortfalls, nine of the previous shortfalls were included in the scope of this partial provisional audit. All nine identified shortfalls have been addressed. These included, training, supervision of residents, timeframes for care and assessment, care interventions, monitoring, medication training, outdoor area, access to outdoor areas, and fire evacuation processes. This audit also identified further shortfall around narrow bathroom doorways in the new wing.

Consumer rights

Not assessed as part of this audit specification

Organisational management

Services are planned, coordinated, and are appropriate to the needs of the residents. An experienced care home manager and clinical nurse manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. The service is in the process of reconfiguring services and diversifying its service offering to the community. They are transitioning to a service that can provide psychogeriatric services as well as hospital and rest home level care. An in-depth transition plan is documented. An orientation programme and comprehensive training plan is in place. Registered nursing cover is provided 24 hours a day, seven days a week and this will continue.

Continuum of service delivery

The assessments and long-term care plans are developed in consultation with the resident/family/whānau. Long-term care plans are developed by the registered nurses and consider routines of residents.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education. The medication charts reviewed meet prescribing requirements and were reviewed at least three-monthly.

Food services and all meals are prepared on site. The kitchen is able to provide meals suitable for hospital and rest home level care residents. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. Choices are available and are provided, with nutritious snacks being provided 24 hours per day. The organisational dietitian reviews the Bupa menu plans.

Safe and appropriate environment

Bupa Rossendale has a current building warrant of fitness. Protective clothing and emergency food supplies are available. The buildings, including the newly refurbished wing, are appropriately heated and ventilated. Bathrooms, personal space areas, and communal areas are suitable for resident's needs. There are processes in place to ensure a safe environment for residents, staff, and visitors within a secure environment. First aid training is provided to staff and is current.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with training in restraint minimisation and challenging behaviour management.

Infection prevention and control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service, including hospital and rest home level care. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Bupa facilities. There have been no outbreaks.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	18	0	1	0	0	0
Criteria	0	41	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Rossendale Dementia Care Home & Hospital is part of the Bupa group of aged care facilities. The facility is certified to provide psychogeriatric (PG) and dementia level care for up to 100 residents. The service has been reconfiguring the facility and as a result bed numbers have reduced to 65 beds due to reconfiguration, refurbishment, closed wings, and converting six double rooms to single rooms. There were 50 residents at the time of audit. All residents were under the Aged Residential Hospital Specialised Services Agreement (ARHSS). The service had already exited dementia level care services and there were no residents under that level of care. The service has a six-stage plan to transition 67 existing psychogeriatric level beds to dual service hospital level care and rest home level care. Once all six stages have been completed the service will provide 89 beds: 67 dual service (rest home and hospital) and 22 secure psychogeriatric level beds. This audit verified stage one; 11 beds as suitable for dual service rest home and hospital level care. The service plans to open the eleven dual service beds 15 January 2022. As a result of the completion of stage one there will be a total of 76

		beds. There is a documented transition plan including risk management. The manager has been in the role since June 2021 and is an experienced Bupa manager. The manager is supported in her role by a clinical manager who was previously the senior nurse/unit coordinator for eight years at this facility. The service management team are supported by; the operations manager who teleconferences at least weekly and visits often, the national quality support person for the Midlands region, and a people partner for the region (human recourses). A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. The care home manager and clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a hospital.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the facility manager, a Bupa relief manager will be rostered on site with support from the clinical nurse manager and registered nurses.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are robust Bupa human resources policies in place, including recruitment, selection, orientation, and staff training and development. Five staff files (one registered nurse and four caregivers) reviewed and a review of the manager's data base for staff training and appraisals, evidenced implementation of the recruitment process, employment contracts and completed orientations. Annual performance appraisals were all up to date, which is an improvement from the previous audit. A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g., RN,

		support staff) and includes documented competencies. The caregivers, when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. The staff education data base documented that all Bupa compulsory and non-compulsory training was up to date, including pain management, falls and behaviours that challenge (all completed November 2021). The training database documents 100% attendance at training as the service has repeated many sessions. This is an improvement from the previous audit. Staff competencies were evidenced for chemical safety (household staff), the Bupa code of conduct, observing and reporting (100% of RNs), behaviours that challenge, complaints management, pressure injury care, cultural care, restraint, health and safety and infection control. The database alerts the manager when staff competencies are due. All staff who administer medications had a medication competency. A review of Careerforce training, including compulsory training for psychogeriatric care (Careerforce unit standards) documents that the service is fully compliant with 99% of all staff having completed compulsory unit standards. The remaining 1% are new to the service. This is an improvement from the previous audit. There are eleven RNs, four have completed interRAI training and four are in the process of completing. Partial provisional audit The service has a robust plan in place to ensure all staff are fully prepared to provide safe care and support to rest home and hospital level residents. The plan includes: The clinical manager, the unit coordinator and any staff who will be rostered on for the new wing for the first two weeks, will be orientated to hospital and rest home level care at a neighbouring Bupa facility. Care staff will be orientated for at least three days, depending on individual staff needs, noting all care staff have been working with hospital (PG level residents).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service	FA	There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a non-clinical care home manager and clinical nurse manager (RN) who both work full time from Monday to Friday. The care home manager and clinical nurse manager share the on-

providers.		call duties. Registered nurse cover is provided 24 hours a day, seven days a week. Separate laundry and cleaning staff are employed seven days a week. A review of the current roster documented that all shifts were fully covered. The manager noted that there has been a turnover of staff since the previous audit, but recruitment has ensured that roster gaps have been filled. Walk arounds during the audit evidenced that residents were supervised by staff and staff were actively engaging with residents with a variety of activities. This is an improvement from the previous audit. At the time of audit three units were open. The remainder of units were empty and in the process of refurbishment. Bed availability has changed since the previous audit due to renovations in each of the units. The Pohutukawa psychogeriatric unit (PG) has 22 of 22 residents. There are two RNs rostered for each of the AM, PM, and night shifts. There are four caregivers rostered for the AM and for the PM shifts and two for the night shift. The Kowhai PG unit has 17 of 17 residents. There are two RNs rostered for each of the AM, PM shifts. There are three caregivers rostered for the AM and for the PM shifts. The Rimu PG unit has 11 of 11 residents. There is one RN rostered for each of the AM, PM shifts. There are two HCAs rostered for the AM and for the PM shifts Kowhai and Rimu share two RNs and three HCAs for the night shift. Partial provisional The new wing of eleven beds will be staffed as if full when opened. There will be one RN rostered for each of the AM, PM, and night shifts. Caregiver rostering includes two long shifts and a short shift for the AM, and also for the PM, there will be one caregiver at night. All staff are employed with existing and new staff. There are currently a three-person activity team (all trained DTs), a weekly programme has been developed for the rest home/hospital.
Standard 1.3.12: Medicine Management	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		residents self-administering due to the nature of the service. All legal requirements had been met for medication storage. There are no standing orders in use. There are no vaccines stored on site. The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent caregivers administer medications. All staff have up-to-date medication competencies, and medication education has been provided in the last year; this is an improvement from the previous audit. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperature are checked daily and were within acceptable limits. Eye drops are dated once opened. Staff sign for the administration of medications electronically. Ten medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted. Records demonstrated that medications are administered as prescribed and the indication for use is documented for 'as required' medications. The effectiveness of 'as required' medications is entered into the electronic medication system and in the progress notes, this includes the effectiveness of PRN analgesia and could be evidenced in the records sampled. Mental health team input into medication management and review was also evident. Part of a medication round was observed, and the staff member was seen to comply with all policy and legislative requirements. Partial provisional The wing has an existing medication room in place, the room includes a fridge and lockable medication cupboards. Current processes around medication management, fridge and room temperature will recommence for the new wing once it is opened. Staff are already recruited and have completed medication training and competencies. There are polices, and procedures in place should residents wish to self-administer medications.
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	The kitchen manager oversees the procurement of the food and management

Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		of the kitchen. All meals are cooked on site. The kitchen was observed to be exceptionally clean and well organised, and a current approved food control plan was in evidence. There is a four-week seasonal menu, which is reviewed by a dietitian at organisational level. The kitchen is able to meet the needs of residents who require special diets, and the chef works closely with the registered nurses on duty. Lip plates are available as required. Supplements are provided to residents with identified weight loss issues. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. Additional snacks are available at all times. Pre-made, moulded puree meals are available for those residents requiring diet modification. The service has worked with family members around meals, puree meals and mealtimes. The service has reported that family members have expressed a high level of satisfaction regarding the meals and the extra information. There is a food control plan expiring April 2022. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. Partial provisional The kitchen is fully equipped and provides a variety of meals for high needs residents. Meals will be supplied to the new wing in hot boxes, there is a spacious dining room in the new wing.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service	FA	Resident files reviewed, identified that family were involved in the care plan development and ongoing care needs of the resident. The initial care plan is developed from the initial assessment and identifies the areas of concern or

delivery.		risk. For all long-term resident files reviewed, the care plan documented interventions that reflected the interRAI assessments. The five care plans reviewed all documented the care and interventions appropriate to the resident need. This included one resident with in-depth interventions around diabetes, blood sugar monitoring, recognition and treatment of hypo and hyper glycaemia and two residents with restraint (one hand holding and one lap belt). This is an improvement from the previous audit. Short-term care plans were utilised for acute health needs such as infections. Specific behavioural management strategies were included in care planning.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	RNs and caregivers report progress against the care plan at least daily, progress notes reviewed were comprehensive. If external nursing or allied health advice is required the RNs will initiate a referral (e.g., to the wound specialist nurse). If external medical advice is required, this will be actioned by the GP. Communication with family is documented in progress notes and on the family communication sheet. Short-term care plans are available for use for changes in health status. Continence products are available and resident files include a urinary continence assessment. Specialist continence advice is available as needed and this could be described by the registered nurse. Care plans documented the continence care and support required for each resident including individualised toileting regimes, and continence products were available according to the continence plan. Monthly weighs have been completed in all long-term files sampled. Referral to dietitian occurs as required, as confirmed in sampled files. The five files reviewed included a resident who required a variety of monitoring. This included restraint, repositioning, intentional rounding, blood sugar monitoring and fluid balance charts. Five post-falls charts were also reviewed for neurological observations. The resident files all included the need for monitoring, either in the long-term care plan or a short-term care plan. All monitoring reviewed was documented according to timeframes. This is an improvement from the previous audit. Wound assessment, wound management plans and monitoring were in place for all identified wounds. All wounds have been reviewed in appropriate

		timeframes. Dressing supplies are available, and the treatment room is stocked for use.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff in the laundry and sluice rooms. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets are available. A spills kit is available. The new wing has a secure chemical cupboard.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a building warrant of fitness displayed that expires December 2022. A reactive and planned maintenance schedule are in place. There is a monthly checklist for planned maintenance including the calibration of medical equipment, functional testing of electrical equipment and hot water temperatures in resident areas. Hot water temperatures in resident areas are stable below 45 degrees Celsius. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained, and residents have access to the gardens. Since the previous audit, outdoor areas that were identified as unsafe have been secured and closed off, the area is included in the overall facility refurbishment plan. Residents have easy access to other, safe, outdoor areas. Safe and accessible outdoor areas are an improvement from the previous audit. Partial provisional The service is implementing their plan to reconfigure services and diversify their offering to the community. The plan specifically includes to ensure that the community can access low/no premium rooms as Bupa have identified this as an equity and service gap. This process involves a six-stage plan to refurbish and rebuild the facility. The plan involves the six units of the service and each area is being upgraded in stages. This audit verified stage one as being suitable to rest home and

		hospital level care and is due to open on 15 January 2022. Stage two and three were in the process of refurbishment at the time of audit and are due to open on 30 March 2022. The wing has eleven individual rooms, each with a vanity, wash sink, and wardrobe. There is a combination of new and existing furniture, including hospital level beds. There is a newly refurbished lounge and dining area with new furniture and access to the outside garden. The wing is spacious with room to easily move around with mobility equipment (link 1.4.3.1).
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	PA Low	Since the previous audit the service has converted all double rooms to single rooms. All bedrooms have hand basins. There are adequate communal toilets/showers available. There is appropriate signage with easy clean flooring and fixtures. Privacy locks indicate whether the toilet/shower is vacant or in use. There are privacy signs on all shower/toilet doors. There are communal toilets near the lounge, dining, and activity areas. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and in larger ones, a hoist if appropriate. Partial provisional The newly refurbished wing has eleven singe rooms. There are two communal toilets and one staff/visitor toilet. There are two separate shower rooms. All toilets and bathrooms have privacy locks and privacy signs. Both bathrooms have spacious internal areas, but access might be difficult as the doors are not wide, and it may be difficult to swing a shower bed into the room with the narrow doors.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is sufficient space in each room to allow care to be provided and for the safe use of mobility equipment, shower chairs and hoists. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. Eleven bedrooms have been refurbished to a high standard, each room has a chair, a vanity, a hand basin, and bed.

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a spacious central lounge and dining room in all units (communities) with each having a quiet/whānau room. Smaller lounges are available for small group or individual activities or for visitors. Tea and coffee making facilities are available. All communal areas are accessible and accommodate the equipment required for the residents. Residents are able to move freely, and furniture is well arranged to facilitate this. Hallways are wide and enable residents to wander safely within their unit. The dining room and lounges accommodate specialised lounge chairs and space is arranged to allow both individual and group activities to occur. All units have outdoor areas with easy access. The new wing has a lounge/dining area, it is light and airy. There is new seating, around a central 'fireplace' as well as occasional furniture. The lounge is homelike and cosey. It can accommodate the residents and associated mobility equipment.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is done on site in a well-equipped laundry. The laundry has a defined dirty and clean area with separate exit and entry doors. There are dedicated laundry staff who work shifts. Personal protective equipment is available in the laundry. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. All chemicals on each of the cleaner's trolley were labelled. Staff were observed to be wearing appropriate protective wear. The sluice rooms and the laundry are locked with a keypad when not in use. Cleaning schedules are maintained. Cleaners have attended chemical safety. The newly refurbished wing has an existing, secure, sluice room. Existing cleaning and laundry schedule will recommence in the new wing once opened.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is at least one staff member on duty at all times with a current first aid certificate. There are sufficient first aid and dressing supplies available. Emergency preparedness plans are accessible to staff and include management of all potential emergency situations. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies. The service has an

		approved fire evacuation scheme. Fire evacuation training and drills have been conducted six-monthly and fire notices were all in place. The service had directions for staff and visitors informing the name of the unit. Fire preparedness is an improvement since the previous audit. Call bells were situated in all communal areas, toilets, bathrooms, and personal bedrooms. Residents were sighted to have call bells within reach during the audit. Where appropriate, sensor mats were also observed to be in use. The service has a visitor's book at reception for all visitors including contractors to sign in and out. Appropriate security systems are in place. The newly refurbished wing is connected to the existing call bell system. Fire training and evacuation systems and practice are included in the existing processes and training.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. There is an outdoor smoking area. All other areas are smoke free.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service, including hospital and rest home level care. The scope of the infection control programme policy and infection control programme description is available. The infection control officer role is undertaken by an RN. There is a job description for the infection control (IC) officer and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The committee and the governing body are responsible for the development of the infection control programme and its review. The IC programme is reviewed annually at head office. Annual quality and infection control goals are set at the beginning of the year. There are quarterly infection control meetings that combine with the health and safety meetings. Monthly reports are provided for quality and staff meetings which all include a discussion of infection control matters. The facility has developed links with the GPs, local laboratory and the infection control and public health departments at the local DHB.

		There is a comprehensive Covid-19 policy and procedures with implemented training for all staff. There are stocks of PPE.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a regional restraint group at an organisation level, which reviews restraint practices. The Quality Committee is also responsible for restraint review and use. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.	PA Low	There are specious bathrooms. The internal aspects of the bathroom are well constructed with waterproof linings and floors and could easily accommodate mobility equipment. The doors to the bathrooms are too narrow for all mobility equipment. It was noted that a close wing, currently being refurbished has wide doors to the bathrooms.	The doors to the bathrooms are too narrow for all mobility equipment, such as a shower trolley.	Ensure that at least one of the two bathrooms has wider doors. Prior to occupancy days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.